		FOR OHF USE					

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2000

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

I. IDPH Facility ID Number: 0042283

Facility Name: ASTA CARE CENTER OF BLOOMINGTON

Address: 1509 NORTH CALHOUN STREET (Number) BLOOMINGTON (City) 61701 (Zip Code)

County: MCLEAN

Telephone Number: (309) 827-6046 **Fax #** (309) 829-1992

IDPA ID Number: 36-1357503

Date of Initial License for Current Owners: 09/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code			Corporation		Other		
			"Sub-S" Corp.				
		X	Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATIO

I have examine
State of Illinois, fc
and certify to the
are true, accurate
applicable instruc
is based on all inf

Intentional mis
in this cost report

Officer or Administrator of Provider	(Signed) (Type or (Title)
Paid Preparer	(Signed) (Print Na and Title) (Firm Na & Addres (Telephor

DPA 3745 (N-4-99)

Print Preview

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

N BY AUTHORIZED FACILITY OFFICER

ed the contents of the accompanying report to the
or the period from 01/01/2000 to 12/31/2000
best of my knowledge and belief that the said contents
and complete statements in accordance with
tions. Declaration of preparer (other than provider)
formation of which preparer has any knowledge.

representation or falsification of any information
may be punishable by fine and/or imprisonment.

(Date)

Print Name) MICHAEL GILLMAN

PRESIDENT

(SEE ATTACHED ACCOUNTANTS' REPORT)

(Date)

ame

) BOB KAGDA/PARTNER

me KRUPNICK, BOKOR, KAGDA & BROOKS, LTD

ss) 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

ne) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

IL478-2471

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	117	Skilled (SNF)	117	42,822	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	117	TOTALS	117	42,822	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,663	2,663	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	26,287	5,595		31,882	11
12	SC					12
13	DD 16 OR LESS					13

D. How many l
NONE

E. List all servi
(E.g., day car
NONE

F. Does the fac

G. Do pages 3 ·
investments
YES

H. Does the BA
YES

I. On what dat
Date started

J. Was the faci
YES

K. Was the fac
YES
of beds certi

Medicare Inter

IV. ACCOUNT

ACCRUAL

14	TOTALS	26,287	5,595	2,663	34,545	14	Is your fiscal

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.67%

Tax Year:
* All facilities

Print Preview

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

bed-hold days during this year were paid by Public Aid?
____ (Do not include bed-hold days in Section B.)

ices provided by your facility for non-patients.
re, "meals on wheels", outpatient therapy)

ility maintain a daily midnight census? YES

& 4 include expenses for services or
not directly related to patient care?
[ ] NO [X]

ALANCE SHEET (page 17) reflect any non-care assets?
[ ] NO [X]

e did you start providing long term care at this location?
09/01/96

lity purchased or leased after January 1, 1978?
[x] Date 09/01/96 NO [ ]

ility certified for Medicare during the reporting year?
[x] NO [ ] If YES, enter number
fied 24 and days of care provided 2240

rmediary ADMINASTAR FEDERAL

TING BASIS

	MODIFIED	
[X]	CASH* [ ]	CASH* [ ]

year identical to your tax year? YES [X] NO [ ]

12/31/00 Fiscal Year: 12/31/00

other than governmental must report on the accrual basis.

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTOI # 0042283 **Report Period**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total
		Salary/Wage	Supplies	Other	Total		
	A. General Services	1	2	3	4	5	6
1	Dietary	176,909	20,521	17,482	214,912		214,912
2	Food Purchase		127,396		127,396		127,396
3	Housekeeping	166,546	26,076	0	192,622		192,622
4	Laundry	52,521	24,010	2,029	78,560		78,560
5	Heat and Other Utilities			125,845	125,845		125,845
6	Maintenance	65,021	32,769	53,393	151,183		151,183
7	Other (specify):*			25,251	25,251		25,251
8	**TOTAL General Services**	460,997	230,772	224,000	915,769		915,769
	B. Health Care and Programs						
9	Medical Director			8,940	8,940		8,940
10	Nursing and Medical Records	987,889	62,739	86,774	1,137,402		1,137,402
10a	Therapy	71,044	586	4,205	75,835		75,835
11	Activities	49,461	9,075	2,167	60,703		60,703
12	Social Services	29,892		0	29,892		29,892
13	Nurse Aide Training			0			
14	Program Transportation			0			
15	Other (specify):*						
16	**TOTAL Health Care and Programs**	1,138,286	72,400	102,086	1,312,772		1,312,772
	C. General Administration						
17	Administrative	82,098		161,590	243,688		243,688
18	Directors Fees			0			
19	Professional Services			68,612	68,612		68,612
20	Dues, Fees, Subscriptions & Promotions			51,754	51,754		51,754
21	Clerical & General Office Expenses	106,089	21,430	55,335	182,854		182,854
22	Employee Benefits & Payroll Taxes			241,219	241,219		241,219
23	Inservice Training & Education			5,825	5,825		5,825
24	Travel and Seminar			0			
25	Other Admin. Staff Transportation			3,836	3,836		3,836
26	Insurance-Prop.Liab.Malpractice			21,750	21,750		21,750
27	Other (specify):*			37,753	37,753		37,753
28	**TOTAL General Administration**	188,187	21,430	647,674	857,291		857,291
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,787,470	324,602	973,760	3,085,832		3,085,832

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of e

Print Preview

l Beginning: 01/01/2000 Ending: 12/31/2000

Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
0	214,912			1
(1,751)	125,645			2
0	192,622			3
0	78,560			4
0	125,845			5
(9,024)	142,159			6
0	25,251			7
(10,775)	904,994			8
0	8,940			9
0	1,137,402			10
0	75,835			10a
0	60,703			11
0	29,892			12
0				13
0				14
0				15
	1,312,772			16
(121,884)	121,804			17
0				18
4,463	73,075			19
(36,215)	15,539			20
75,653	258,507			21
0	241,219			22
0	5,825			23
498	498			24
6,574	10,410			25
1,256	23,006			26
(26,933)	10,820			27
(96,588)	760,703			28
(107,363)	2,978,469			29

ach reclassification.

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTOI # 0042283 **Report Period**

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total
		Salary/Wage	Supplies	Other	Total		
	D. Ownership	1	2	3	4	5	6
30	Depreciation			22,231	22,231		22,231
31	Amortization of Pre-Op. & Org.						
32	Interest			31,579	31,579		31,579
33	Real Estate Taxes			35,911	35,911		35,911
34	Rent-Facility & Grounds			482,621	482,621		482,621
35	Rent-Equipment & Vehicles			6,142	6,142		6,142
36	Other (specify):* Amort software			523	523		523
37	**TOTAL Ownership**			579,007	579,007		579,007
	Ancillary Expense						
	E. Special Cost Centers						
38	Medically Necessary Transportation						
39	Ancillary Service Centers			274,477	274,477		274,477
40	Barber and Beauty Shops						
41	Coffee and Gift Shops						
42	Provider Participation Fee			64,234	64,234		64,234
43	Other (specify):*						
44	**TOTAL Special Cost Centers**			338,711	338,711		338,711
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,787,470	324,602	1,891,478	4,003,550	0	4,003,550

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

Print Preview

l Beginning: 01/01/2000 Ending: 12/31/2000

Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
(4,454)	17,777			30
0				31
(514)	31,065			32
0	35,911			33
0	482,621			34
3,807	9,949			35
0	523			36
(1,161)	577,846			37
0				38
0	274,477			39
0				40
0				41
0	64,234			42
0				43
	338,711			44
(108,524)	3,895,026			45

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF IL

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report P

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Sche
In column 2 below, reference the line on which the particular cost was included. (Se

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(4,454)	30		9
10	Interest and Other Investment Income	(514)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,751)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties		21		18
19	Entertainment	0	20		19
20	Contributions	(3,624)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	(37,753)	27		24
25	Fund Raising, Advertising and Promotional	(32,630)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(9,024)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (89,750)		$	30

B. If
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OHF USE ONLY									
48		49		50		51		52	

Print Preview

eriod Beginning: 01/01/2000 Ending: 12/31/2000

dule V, pages 3 or 4 via column 7.
e instructions.)

there are expenses experienced by the facility which do not appear in the
neral ledger, they should be entered below.(See instructions.)

	1 Amount	2 Reference	
Non-Paid Workers-Attach Schedule*	$		31
Donated Goods-Attach Schedule*			32
Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization Costs (Schedule VII)	(18,774)	SCHED	34
Other- Attach Schedule	0	TTACHED	35
SUBTOTAL (B): (sum of lines 31-35)	$ (18,774)		36
TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (108,524)		37

ese costs are only allowable if they are necessary to meet minimum
nsing standards. Attach a schedule detailing the items included
these lines.

re the following expenses included in Sections A to D of pages 3
l 4? If so, they should be reclassified into Section E. Please
erence the line on which they appear before reclassification.
e instructions.)

	1 Yes	2 No	3 Amount	4 Reference	
Medically Necessary Transport.		X	$		38
					39
Gift and Coffee Shops		X			40
Barber and Beauty Shops		X			41
Laboratory and Radiology		X			42
Prescription Drugs		X			43
Exceptional Care Program		X			44
Other-Attach Schedule					45
Other-Attach Schedule					46

TOTAL (C): (sum of lines 38-46)	**$**		**47**

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have
1. **Highlight the other adjustr starting at B44 and continu Be sure the columns highli**
2. **Push the Print Other Adju button.**

STATE OF ILLINOIS **Page 5A**

Facility Name **ASTA CARE CENTER OF BLOOMINGTON**

ID# **0042283**

Report Period Beginning: **01/01/2000**

Ending: **12/31/2000**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(1,751)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7**	0
8	**Laundry for Non-Patients**	0	4	**Line 8**	(1,751)
9	**Non-Straightline Depreciation**	(4,454)	30	**Line 9**	0
10	**Interest and Other Investment Income**	(514)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	2	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(1,751)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15**	0
17	**Non-Care Related Fees**	0	20	**Line 16**	0
18	**Fines and Penalties**	0	21	**Line 17**	0
19	**Entertainment**	0	20	**Line 18**	0
20	**Contributions**	(3,624)	20	**Line 19**	0
21	**Owner or Key-Man Insurance**	0	22	**Line 20**	(36,254)
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 21**	0

Print Other Adjustm

23	**Malpractice Insurance for Individuals**	0	26	**Line 22**	0
24	**Bad Debt**	(37,753)	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(32,630)	20	**Line 24**	0
26	**Income & IL Personal Property ReplacementTaxes**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26**	0
28	**Yellow Page Advertising**	0	20	**Line 27**	(37,753)
29	**Non-Paid Workers**	0	0	**Line 28**	(74,007)
30	**Donated Goods**	0	0	**Line 29**	(75,758)
31	**Amortization Expense**	0	0	**Line 30**	(4,454)
32				**Line 31**	0
33				**Line 32**	(514)
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	(4,968)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(80,726)
47					
48					
49					
50					
51					
52					
53					
54					
55					
56					

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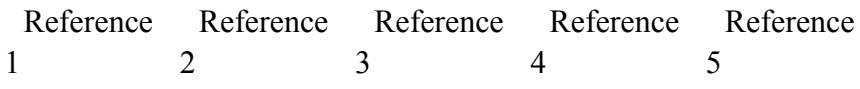
Reference 1
Reference 2
Reference 3
Reference 4
Reference 5

Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15

Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26

Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39

Reference 40 Reference 41 Reference 42 Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Peri

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E
	A. General Services							
1	Dietary	0	0	0	0	0	0	0
2	Food Purchase	(1,751)	0	0	0	0	0	0
3	Housekeeping	0	0	0	0	0	0	0
4	Laundry	0	0	0	0	0	0	0
5	Heat and Other Utilities	0	0	0	0	0	0	0
6	Maintenance	0	0	0	0	0	0	0
7	Other (specify):*	0	0	0	0	0	0	0
8	**TOTAL General Services**	(1,751)	0	0	0	0	0	0
	B. Health Care and Programs							
9	Medical Director	0	0	0	0	0	0	0
10	Nursing and Medical Records	0	0	0	0	0	0	0
10a	Therapy	0	0	0	0	0	0	0
11	Activities	0	0	0	0	0	0	0
12	Social Services	0	0	0	0	0	0	0
13	Nurse Aide Training	0	0	0	0	0	0	0
14	Program Transportation	0	0	0	0	0	0	0
15	Other (specify):*	0	0	0	0	0	0	0
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0
	C. General Administration							
17	Administrative	0	(121,884)	0	0	0	0	0
18	Directors Fees	0	0	0	0	0	0	0
19	Professional Services	0	4,463	0	0	0	0	0
20	Fees, Subscriptions & Promotions	(36,254)	39	0	0	0	0	0
21	Clerical & General Office Expenses	0	75,653	0	0	0	0	0
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0
23	Inservice Training & Education	0	0	0	0	0	0	0
24	Travel and Seminar	0	498	0	0	0	0	0
25	Other Admin. Staff Transportation	0	6,574	0	0	0	0	0
26	Insurance-Prop.Liab.Malpractice	0	1,256	0	0	0	0	0
27	Other (specify):*	(37,753)	10,820	0	0	0	0	0
28	**TOTAL General Administration**	(74,007)	(22,581)	0	0	0	0	0
	TOTAL Operating Expense							

29	**(sum of lines 8,16 & 28)**	**(75,758)**	**(22,581)**	**0**	**0**	**0**	**0**	**0**

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

Summary A

od Beginning: 01/01/2000 Ending: 12/31/2000

PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
0	0	0	0	0	1
0	0	0	0	(1,751)	2
0	0	0	0	0	3
0	0	0	0	0	4
0	0	0	0	0	5
0	0	0	0	0	6
0	0	0	0	0	7
0	0	0	0	(1,751)	8
0	0	0	0	0	9
0	0	0	0	0	10
0	0	0	0	0	10a
0	0	0	0	0	11
0	0	0	0	0	12
0	0	0	0	0	13
0	0	0	0	0	14
0	0	0	0	0	15
0	0	0	0	0	16
0	0	0	0	(121,884)	17
0	0	0	0	0	18
0	0	0	0	4,463	19
0	0	0	0	(36,215)	20
0	0	0	0	75,653	21
0	0	0	0	0	22
0	0	0	0	0	23
0	0	0	0	498	24
0	0	0	0	6,574	25
0	0	0	0	1,256	26
0	0	0	0	(26,933)	27
0	0	0	0	(96,588)	28

0	**0**	**0**	**0**	**(98,339)**	**29**

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 **Report Per**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E
30	Depreciation	(4,454)	0	0	0	0	0	0
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0
32	Interest	(514)	0	0	0	0	0	0
33	Real Estate Taxes	0	0	0	0	0	0	0
34	Rent-Facility & Grounds	0	0	0	0	0	0	0
35	Rent-Equipment & Vehicles	0	3,807	0	0	0	0	0
36	Other (specify):*	0	0	0	0	0	0	0
37	**TOTAL Ownership**	(4,968)	3,807	0	0	0	0	0
	Ancillary Expense							
	E. Special Cost Centers							
38	Medically Necessary Transportation	0	0	0	0	0	0	0
39	Ancillary Service Centers	0	0	0	0	0	0	0
40	Barber and Beauty Shops	0	0	0	0	0	0	0
41	Coffee and Gift Shops	0	0	0	0	0	0	0
42	Provider Participation Fee	0	0	0	0	0	0	0
43	Other (specify):*	0	0	0	0	0	0	0
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(80,726)	(18,774)	0	0	0	0	0

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.

5. The amounts in the column Q are linked to page 4.

Summary B

'iod Beginning: 01/01/2000 Ending: 12/31/2000

PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
0	0	0	0	(4,454)	30
0	0	0	0	0	31
0	0	0	0	(514)	32
0	0	0	0	0	33
0	0	0	0	0	34
0	0	0	0	3,807	35
0	0	0	0	0	36
0	0	0	0	(1,161)	37
0	0	0	0	0	38
0	0	0	0	0	39
0	0	0	0	0	40
0	0	0	0	0	41
0	0	0	0	0	42
0	0	0	0	0	43
0	0	0	0	0	44
0	0	0	0	(99,500)	45

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

1 OWNERS		2 RELATED NURSING HOMES	
Name	Ownership %	Name	City
LIST ATTACHED		LIST ATTACHED	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization
1	V	17	MANAGEMENT FEES	$ 161,590	
2	V	17	OFFICER SALARY		ASTA HEALTHCARE COMPANY
3	V	19	PROFESSIONAL FEES		ASTA HEALTHCARE COMPANY
4	V	20	LICENSES & PERMITS		ASTA HEALTHCARE COMPANY
5	V	21	CLERICAL		ASTA HEALTHCARE COMPANY
6	V	24	EDUCATION & SEMINAR		ASTA HEALTHCARE COMPANY
7	V	25	TRANSPORTATION		ASTA HEALTHCARE COMPANY
8	V	26	INSURANCE		ASTA HEALTHCARE COMPANY
9	V	27	EMPLOYEE BENEFITS		ASTA HEALTHCARE COMPANY
10	V	35	COPY & AUTO LEASE		ASTA HEALTHCARE COMPANY
11	V				
12	V				

13	V				
14	Total			$ 161,590	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line numb
5. The adjustments entered on this page will automatically transfer to the summary pages.

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

s. Attach an additional schedule if necessary.

	3 OTHER RELATED BUSINESS ENTITIES		
	Name	City	Type of Business
	SEE ATTACHED		

	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
		$	$ (161,590)	1	-161590
		39,706	39,706	2	39706
		4,463	4,463	3	4463
		39	39	4	39
		75,653	75,653	5	75653
		498	498	6	498
		6,574	6,574	7	6574
		1,256	1,256	8	1256
		10,820	10,820	9	10820
		3,807	3,807	10	3807
				11	
				12	

				13
		$ 142,816	$ * (18,774)	14

.

	Line	Line	Line	Line	Line
er 10a.	1	2	3	4	5

Line 6	Line 7	Line 9	Line 10	Line 10a	Line 11	Line 12	Line 13	Line 14	Line 15

Line 17	Line 18	Line 19	Line 20	Line 21	Line 22	Line 23	Line 24	Line 25	Line 26

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
27	30	31	32	33	34	35	36	38	39

Line	Line	Line	Line
40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization
15	V			$	
16	V				
17	V				
18	V				
19	V				
20	V				
21	V				
22	V				
23	V				
24	V				
25	V				
26	V				
27	V				
28	V				
29	V				
30	V				
31	V				
32	V				
33	V				
34	V				
35	V				
36	V				
37	V				
38	V				

39	Total			$	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number
5. The adjustments entered on this page will automatically transfer to the summary pages.

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

	6	7	8 Difference:	
	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
		$	$	15
				16
				17
				18
				19
				20
				21
				22
				23
				24
				25
				26
				27
				28
				29
				30
				31
				32
				33
				34
				35
				36
				37
				38

Sum_6A

	$	**$ ***	**39**

10a.

Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization
15	V			$	
16	V				
17	V				
18	V				
19	V				
20	V				
21	V				
22	V				
23	V				
24	V				
25	V				
26	V				
27	V				
28	V				
29	V				
30	V				
31	V				
32	V				
33	V				
34	V				
35	V				
36	V				
37	V				
38	V				

39	Total			$	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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5. The adjustments entered on this page will automatically transfer to the summary pages.

Report Period Beginning: 01/01/2000 **Ending:** 12/31/2000

	6	7	8 Difference:	
	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
		$	$	15
				16
				17
				18
				19
				20
				21
				22
				23
				24
				25
				26
				27
				28
				29
				30
				31
				32
				33
				34
				35
				36
				37
				38

Sum_6B

	$	**$ ***	**39**

10a.

Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization
15	V			$	
16	V				
17	V				
18	V				
19	V				
20	V				
21	V				
22	V				
23	V				
24	V				
25	V				
26	V				
27	V				
28	V				
29	V				
30	V				
31	V				
32	V				
33	V				
34	V				
35	V				
36	V				
37	V				
38	V				

39	Total			$	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number
5. The adjustments entered on this page will automatically transfer to the summary pages.

Report Period Beginning: 01/01/2000 **Ending:** 12/31/2000

	6	7	8 Difference:	
	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
		$	$	15
				16
				17
				18
				19
				20
				21
				22
				23
				24
				25
				26
				27
				28
				29
				30
				31
				32
				33
				34
				35
				36
				37
				38

Sum_6C

	$	**$ ***	**39**

10a.

Print Page 6D

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization
15	V			$	
16	V				
17	V				
18	V				
19	V				
20	V				
21	V				
22	V				
23	V				
24	V				
25	V				
26	V				
27	V				
28	V				
29	V				
30	V				
31	V				
32	V				
33	V				
34	V				
35	V				
36	V				
37	V				
38	V				

39	Total			$	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number
5. The adjustments entered on this page will automatically transfer to the summary pages.

Report Period Beginning: 01/01/2000 **Ending:** 12/31/2000

	6	7	8 Difference:	
	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
		$	$	15
				16
				17
				18
				19
				20
				21
				22
				23
				24
				25
				26
				27
				28
				29
				30
				31
				32
				33
				34
				35
				36
				37
				38

Sum_6D

	$	**$ ***	**39**

10a.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTO # 0042283 Report Perio

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hou Week Dev Facility and Work Hours
1						
2						
3						
4						
5		SEE ATTACHED				
6						
7						
8						
9						
10						
11						
12						
13						

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nur of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE TH

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RE

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE

Print Preview

l Beginning: 01/01/2000 Ending: 12/31/2000

of compensation from this home

6 irs Per Work oted to this l % of Total Week	7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
Percent	Description	Amount		
		$		1
				2
				3
				4
				5
				6
				7
				8
				9
				10
				11
				12
	TOTAL	$		13

sing homes, attach a schedule detailing the name(s)
HE OTHER NURSING HOMES' COST REPORTS

report (i.e., management fees).
ECEIVED FROM THIS HOME,

OF SUCH COMPENSATION

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Repor

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	
1	17	OFFICER SALARY	PER RESIDENT DAY	160,952	5	$
2	19	PROFESSIONAL FEES	PER RESIDENT DAY	160,952	5	
3	20	LICENSES & PERMITS	PER RESIDENT DAY	160,952	5	
4	21	CLERICAL	PER RESIDENT DAY	160,952	5	
5	24	EDUCATION & SEMINARS	PER RESIDENT DAY	160,952	5	
6	25	TRANSPORTATION	PER RESIDENT DAY	160,952	5	
7	26	INSURANCE	PER RESIDENT DAY	160,952	5	
8	27	EMPLOYEE BENEFITS	PER RESIDENT DAY	160,952	5	
9	35	EQUIPMENT LEASE	PER RESIDENT DAY	160,952	5	
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						

25	TOTALS					$

Print Preview

't Period Beginning: 01/01/2000 Ending: 2/31/2000

thru 8I

Name of Related Organization ASTA HEALTHCARE
Street Address 134 N. MCLEAN
City / State / Zip Code ELGIN,IL 60123
Phone Number (847)742-8822
Fax Number (847)742-9013

6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
185,000	$ 185,000	34,545	$ 39,706	1
20,792		34,545	4,463	2
182		34,545	39	3
352,482	316,460	34,545	75,653	4
2,319		34,545	498	5
30,630		34,545	6,574	6
5,850		34,545	1,256	7
50,414		34,545	10,820	8
17,736		34,545	3,807	9
				10
				11
				12
				13
				14
				15
				16
				17
				18
				19
				20
				21
				22
				23
				24

665,405	**$ 501,460**		**$ 142,816**	**25**

Print Page 8A

STATE OF ILLINO

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Repor

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	
1						$
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						

25	TOTALS					$

Print Preview

t Period Beginning: 01/01/2000 **Ending:** 12/31/2000

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	$		$	1
				2
				3
				4
				5
				6
				7
				8
				9
				10
				11
				12
				13
				14
				15
				16
				17
				18
				19
				20
				21
				22
				23
				24

	$		**$**	**25**

Print Page 8B

STATE OF ILLINO

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Repor

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	
1						$
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						

25	TOTALS					$

Print Preview

't Period Beginning: 01/01/2000 Ending: 12/31/2000

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	$		$	1
				2
				3
				4
				5
				6
				7
				8
				9
				10
				11
				12
				13
				14
				15
				16
				17
				18
				19
				20
				21
				22
				23
				24

	$		**$**	**25**

Print Page 8C

STATE OF ILLINO

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Repor

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	
1						$
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						

25	TOTALS					$

Print Preview

't Period Beginning: 01/01/2000 Ending: 12/31/2000

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	$		$	1
				2
				3
				4
				5
				6
				7
				8
				9
				10
				11
				12
				13
				14
				15
				16
				17
				18
				19
				20
				21
				22
				23
				24

	$		**$**	**25**

Print Page 8D

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	
1						$
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						

25	TOTALS					$

Print Preview

't Period Beginning: 01/01/2000 Ending: 12/31/2000

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	$		$	1
				2
				3
				4
				5
				6
				7
				8
				9
				10
				11
				12
				13
				14
				15
				16
				17
				18
				19
				20
				21
				22
				23
				24

	$		**$**	**25**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount o	
		YES	NO				Original	
	A. Directly Facility Related							
	Long-Term							
1							$	$
2								
3								
4								
5								
	Working Capital							
6	AMERICAN NATIONAL BANK		X	WORKING CAPITAL	INTEREST	REVOLV	500,000	
7								
8								
9	TOTAL Facility Related						$ 500,000	$
	B. Non-Facility Related*							
10								
11								
12								
13								
14	TOTAL Non-Facility Related						$	$
15	TOTALS (line 9+line14)						$ 500,000	$

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Print Preview

inning: 01/01/2000 Ending: 12/31/2000

7	8	9	10	
f Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			$	1
				2
				3
				4
				5
375,000	REVOLV	PRIME +	31,579	6
				7
				8
375,000			$ 31,579	9
				10
				11
				12
				13
			$	14
375,000			$ 31,579	15

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON **#** 0042283 **Repo**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, deta

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Sche
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed

6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND $ _____ **For** 19 _____ **Tax Year.** **(Attach a copy of the real estate tax appeal b**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	32,027	8
	1996	33,924	9
	1997	35,588	10
	1998	36,603	11
	1999	36,257	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

13	
14	
15	
16	

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit e**

This denial must be no more than four years old at the time the cost repo

Print Preview

rt Period Beginning: 01/01/2000 **Ending:** 12/31/2000

	$ 36,603	1
ail below.)	$ 36,257	2
	$ (346)	3
	$ 36,257	4
edule V, sections A, B or C. with the county.)	$	5
oard's decision.)	$	6
	$ 35,911	7

FOR OHF USE ONLY		
FROM R. E. TAX STATEMENT FOR 1999	$	13
PLUS APPEAL COST FROM LINE 5	$	14
LESS REFUND FROM LINE 6	$	15
AMOUNT TO USE FOR RATE CALCULATION	$	16

ntity.

rt is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 0 B. General Construction Type: Exterior Fra

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organiz

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nu List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over W

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-opera

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	
1		0		$
2				

3	TOTALS		0		$

Print Preview

rt Period Beginning: 01/01/2000 Ending: 12/31/2000

me Number of Stories

(c) Rent from Completely Unrelated Organization.

instructions.)

ation.

(c) Rent equipment from Completely Unrelated Organization.

. See instructions.)

this nursing home's grounds
rse aide training facilities, etc.)

YES X NO

hich it is Being Amortized:

ıting costs.)

4

Cost	
	1
	2

	0	3

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Perio

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years
4					$	$	
5							
6							
7							
8							
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3						
9	ROOF & DOORS			1997	8,588	220	39
10	FIRE ALARM CONTROL PANEL			1998	2,880	74	39
11	CHECK VALVES INSTALLATION			1998	3,192	82	39
12	WATER HEATER			1998	5,965	153	39
13	ROOF			1999	14,774	537	27.5
14	GARAGE			1999	9,320	339	27.5
15	FENCE			1999	3,510	234	15
16	A/C ROOF UNIT COMPRESSOR			1999	2,314	84	27.5
17	VALVES			2000	1,232	24	27.5
18	BUILT IN CHART RACKS			2000	1,980	39	27.5
19	ROOF			2000	13,310	266	27.5
20	ELECTRICAL WORK			2000	1,600	32	27.5
21	DISPOSAL			2000	1,820	36	27.5
22	ELECTRICAL			2000	1,774	35	27.5
23	WATER LINE			2000	3,100	61	27.5
24	CURTAINS			2000	1,679	240	10
25	CARPETING			2000	4,599	657	10
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 3,113	

*Total beds on this schedule must agree with page 2.

****Improvement type must be detailed in order for the cost report to be considered complete.**

Print Preview

D

Hide Pgs 12A thru 12D

d Beginning: 01/01/2000 Ending: 12/31/2000

7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
$	$	$	4
			5
			6
			7
			8
220		706	9
74		188	10
82		208	11
153		389	12
537		828	13
339		523	14
234		361	15
84		130	16
24		24	17
39		39	18
266		266	19
32		32	20
36		36	21
35		35	22
61		61	23
84	(156)	84	24
230	(427)	230	25
			26
			27
			28
			29
			30
			31
			32
			33
			34
			35
$ 2,530	$ (583)	$ 4,140	36

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Pag

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Perio

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years
4					$	$	
5							
6							
7							
8							
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3						
9							
10							
11							
12							
13							
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34							
35							
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$	

***Total beds on this schedule must agree with page 2.**
****Improvement type must be detailed in order for the cost report to be considered complete.**

Print Preview

d Beginning: 01/01/2000 Ending: 12/31/2000

7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
$	$	$	4
			5
			6
			7
			8
			9
			10
			11
			12
			13
			14
			15
			16
			17
			18
			19
			20
			21
			22
			23
			24
			25
			26
			27
			28
			29
			30
			31
			32
			33
			34
			35
$	$	$	36

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Pag

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Per

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years
4					$	$	
5							
6							
7							
8							
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3						
9							
10							
11							
12							
13							
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32							
33							
34							
35							
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$	

***Total beds on this schedule must agree with page 2.**
****Improvement type must be detailed in order for the cost report to be considered complete.**

Print Preview

Page 12B

iod Beginning: 01/01/2000 Ending: 12/31/2000

	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
	$	$	$	4
				5
				6
				7
				8
				9
				10
				11
				12
				13
				14
				15
				16
				17
				18
				19
				20
				21
				22
				23
				24
				25
				26
				27
				28
				29
				30
				31
				32
				33
				34
				35
	$	$	$	36

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Per

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years
4					$	$	
5							
6							
7							
8							
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3						
9							
10							
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31							
32							
33							
34							
35							
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$	

***Total beds on this schedule must agree with page 2.**
****Improvement type must be detailed in order for the cost report to be considered complete.**

Print Preview

iod Beginning: 01/01/2000 Ending: 12/31/2000

	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
	$	$	$	4
				5
				6
				7
				8
				9
				10
				11
				12
				13
				14
				15
				16
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				24
				25
				26
				27
				28
				29
				30
				31
				32
				33
				34
				35
	$	$	$	36

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Per

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years
4					$	$	
5							
6							
7							
8							
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3						
9							
10							
11							
12							
13							
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28							
29							
30							
31							
32							
33							
34							
35							
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$	

***Total beds on this schedule must agree with page 2.**
****Improvement type must be detailed in order for the cost report to be considered complete.**

Print Preview

iod Beginning: 01/01/2000 Ending: 12/31/2000

	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
	$	$	$	4
				5
				6
				7
				8
				9
				10
				11
				12
				13
				14
				15
				16
				17
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				28
				29
				30
				31
				32
				33
				34
				35
	$	$	$	36

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Be

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Stra Dep
37	Purchased in Prior Years	$ 77,849	$ 13,238	$
38	Current Year Purchases	13,872	1,982	
39	Fully Depreciated Assets			
40				
41	TOTALS	$ 91,721	$ 15,220	$

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Stra Dep
42	ADMIN.,ACTIV.	1995 FORD	1997	$ 33,841	$ 3,898	$
43						
44						
45						
46	TOTALS			$ 33,841	$ 3,898	$

E. Summary of Care-Related Assets

		1 Reference
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4		
52		$	$	$	52	58
53					53	59
54					54	60
55					55	61
56					56	

57	TOTALS	$	$	$	57	*

**

Print Preview

eginning: 01/01/2000 Ending: 12/31/2000

ight Line reciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
7,785	$ (5,453)	10	$ 22,778	37
694	(1,288)	10	694	38
				39
				40
8,479	$ (6,741)		$ 23,472	41

ight Line reciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
6,768	$ 2,870	5	$ 27,072	42
				43
				44
				45
6,768	$ 2,870		$ 27,072	46

	2 Amount		
	$ #VALUE!	47	
	$ 22,231	48	
	$ 17,777	49	**
	$ (4,454)	50	
	$ 54,684	51	

G. Construction-in-Progress

Description	Cost	
	$	58
		59
		60
	$	61

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: BLOOMINGTON PROPERTY,L.L.C.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Y Renewal C
3	Original Building:		117	9/1/96	$ 482,621	30	
4	Additions						
5							
6							
7	TOTAL		117		$ 482,621 **		

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 6,142 Description: COPY MACHINE
(Attach a schedule detailing th

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

Print Preview

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

'ears Option*	
	3
	4
	5
	6
	7

10. Effective dates of current rental agreement:

Beginning 09/01/96

Ending 09/01/26

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2001	$ 505,068
13.	12/31/2002	$ 527,516
14.	12/31/2003	$ 527,516

ıe breakdown of movable equipment)

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON #

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]

IN OTHER FACILITY [ ]

COMMUNITY COLLEGE [ ]

HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	
			Facility			
			Drop-outs	Completed	Contract	
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

Print Preview

y name, address and cost per aide trained in that facility.)

3. CLINICAL PORTION:

IN-HOUSE PROGRAM ☐

IN OTHER FACILITY ☐

HOURS PER AIDE ____

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

4
Total

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	
	Service	Schedule V Line & Column Reference	Staff			Outside Pra (other than c	
			Units of Service	Cost		Units	
1	Licensed Occupational Therapist		hrs	$			$
2	Licensed Speech and Language Development Therapist		hrs				
3	Licensed Recreational Therapist		hrs				
4	Licensed Physical Therapist		hrs				
5	Physician Care		visits				
6	Dental Care		visits				
7	Work Related Program		hrs				
8	Habilitation		hrs				
9	Pharmacy		# of prescrpts				
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs				
11	Academic Education		hrs				
12	Exceptional Care Program						
13	Other (specify):						
14	TOTAL			$			$

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be deta

Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not b on this schedule.

Print Preview

ort Period Beginning: 01/01/2000 Ending: 12/31/2000

5	6	7	8	
actitioner onsultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
71,815	$		$ 71,815	1
12,003			12,003	2
				3
69,250			69,250	4
				5
				6
				7
				8
	56,150		56,150	9
				10
				11
				12
	65,259		65,259	13
153,068	$ 121,409		$ 274,477	14

iled on

ɔe listed

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*		
	A. Current Assets				
1	Cash on Hand and in Banks	$ 3,353	$	1	26
2	Cash-Patient Deposits			2	27
	Accounts & Short-Term Notes Receivable-				28
3	Patients (less allowance)	539,734		3	29
4	Supply Inventory (priced at)			4	30
5	Short-Term Investments			5	
6	Prepaid Insurance	13,221		6	31
7	Other Prepaid Expenses	816		7	32
8	Accounts Receivable (owners or related parties)			8	33
9	Other(specify): REAL ESTATE ESCROW DEP	27,272		9	34
	TOTAL Current Assets				35
10	**(sum of lines 1 thru 9)**	$ 584,396	$	10	
	B. Long-Term Assets				36
11	Long-Term Notes Receivable			11	37
12	Long-Term Investments			12	
13	Land			13	38
14	Buildings, at Historical Cost			14	
15	Leasehold Improvements, at Historical Cost	75,359		15	39
16	Equipment, at Historical Cost	131,840		16	40
17	Accumulated Depreciation (book methods)	(85,815)		17	41
18	Deferred Charges			18	42
19	Organization & Pre-Operating Costs			19	
	Accumulated Amortization -				43
20	Organization & Pre-Operating Costs			20	44
21	Restricted Funds			21	
22	Other Long-Term Assets (specify):			22	45
23	Other(specify): COMPUTER SOFTWARE	5,312		23	
	TOTAL Long-Term Assets				46
24	**(sum of lines 11 thru 23)**	$ 126,696	$	24	
					47
	TOTAL ASSETS				
25	**(sum of lines 10 and 24)**	$ 711,092	$	25	48

***(See instructions.)**

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Report Period Beginning: 01/01/2000 **Ending:** 12/31/2000
(last day of reporting year)

	1 Operating	2 After Consolidation*	
C. Current Liabilities			
Accounts Payable	$ 180,561	$	26
Officer's Accounts Payable			27
Accounts Payable-Patient Deposits			28
Short-Term Notes Payable	375,000		29
Accrued Salaries Payable	20,120		30
Accrued Taxes Payable (excluding real estate taxes)	5,616		31
Accrued Real Estate Taxes(Sch.IX-B)	36,257		32
Accrued Interest Payable			33
Deferred Compensation			34
Federal and State Income Taxes			35
Other Current Liabilities(specify):			
Due to Related Parties	59,630		36
			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	$ 677,184	$	38
D. Long-Term Liabilities			
Long-Term Notes Payable	200,000		39
Mortgage Payable			40
Bonds Payable			41
Deferred Compensation			42
Other Long-Term Liabilities(specify):			
			43
			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$ 200,000	$	45
TOTAL LIABILITIES (sum of lines 38 and 45)	$ 877,184	$	46
TOTAL EQUITY(page 18, line 24)	$ (166,092)	$	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 711,092	$	48

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Repo

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 85,830	1
2	Restatements (describe):		2
3	ROUNDING	33	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 85,863	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(251,955)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (251,955)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (166,092)	24

*** This must agree with p**

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ort Period Beginning: 01/01/2000 Ending: 12/31/2000

*

page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning:

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All re classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,589,951	1
2	Discounts and Allowances for all Levels	5,514	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,595,465	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	155,616	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 155,616	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	514	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 514	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**DISCOUNTS**		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29

	Expenses
	A. Operating Expenses
31	General Services
32	Health Care
33	General Administration
	B. Capital Expense
34	Ownership
	C. Ancillary Expense
35	Special Cost Centers
36	Provider Participation Fee
	D. Other Expenses (specify):
37	
38	
39	
40	**TOTAL EXPENSES (sum of l**
41	**Income before Income Taxes (**
42	**Income Taxes**
43	**NET INCOME OR LOSS FOR**

* **This must agree with page 4, li**

** **Does this agree with taxable in Tax Return?** NO

*** **See the instructions. If this tota against interest expense on Sch detailed explanation.**

30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	**$**	**3,751,595**	**30**

******Provide a detailed breakdown o**

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01/01/2000 Ending: 12/31/2000

quired

	Amount	
	$ 915,769	31
	1,312,772	32
	857,291	33
	579,007	34
	274,477	35
	64,234	36
		37
		38
		39
ines 31 thru 39)*	$ 4,003,550	40
line 30 minus line 40)**	(251,955)	41
		42
R THE YEAR (line 41 minus line 42)	$ (251,955)	43

ne 45, column 4.

come (loss) per Federal Income
If not, please attach a reconciliation.

al amount has not been offset
iedule V, line 32, please include a

of "Other Revenue" on an attached sheet.

STATE OF ILLIN

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

B. C

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage		
1	Director of Nursing	1,895	2,111	$ 43,778	$ 20.74	1	
2	Assistant Director of Nursing	1,134	1,253	30,957	24.71	2	35
3	Registered Nurses	16,068	17,122	304,605	17.79	3	36
4	Licensed Practical Nurses	10,268	11,144	172,847	15.51	4	37
5	Nurse Aides & Orderlies	38,157	40,565	407,272	10.04	5	38
6	Nurse Aide Trainees					6	39
7	Licensed Therapist					7	40
8	Rehab/Therapy Aides	6,656	7,076	71,044	10.04	8	41
9	Activity Director	2,040	2,233	22,220	9.95	9	42
10	Activity Assistants	3,112	3,315	27,241	8.22	10	43
11	Social Service Workers	1,577	1,680	29,892	17.79	11	44
12	Dietician					12	45
13	Food Service Supervisor					13	46
14	Head Cook	7,078	7,416	79,143	10.67	14	47
15	Cook Helpers/Assistants	13,402	14,001	97,766	6.98	15	48
16	Dishwashers					16	
17	Maintenance Workers	5,317	5,886	65,021	11.05	17	49
18	Housekeepers	21,522	23,035	166,546	7.23	18	
19	Laundry	6,787	7,264	52,521	7.23	19	
20	Administrator	2,066	2,315	82,098	35.46	20	
21	Assistant Administrator					21	
22	Other Administrative					22	
23	Office Manager					23	
24	Clerical	8,581	9,233	106,089	11.49	24	
25	Vocational Instruction					25	
26	Academic Instruction					26	
27	Medical Director					27	50
28	Qualified MR Prof. (QMRP)					28	51
29	Resident Services Coordinator					29	52
30	Habilitation Aides (DD Homes)					30	
31	Medical Records					31	53
32	Other Health Care(specify)					32	

C. C

33	Other(specify) CLERICAL NURS	2,300	2,474	28,430	11.49	33
34	TOTAL (lines 1 - 33)	147,960	158,123	$ 1,787,470 *	$ 11.30	34

*** This total must agree with page 4, column 1, line 45.** **** See instructions.**

Print Preview

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Report Period Beginning: 01/01/2000 Ending: 12/31/2000

ONSULTANT SERVICES

	1 Number of Hrs. Paid & Accrued		2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
Dietary Consultant	M	$	5,419	1-3	35
Medical Director	O		8,940	9-3	36
Medical Records Consultant	N		1,700	10-3	37
Nurse Consultant	T		0	10-3	38
Pharmacist Consultant	H		600	10-3	39
Physical Therapy Consultant	L		2,900	10a-3	40
Occupational Therapy Consultant	Y		1,305	10a-3	41
Respiratory Therapy Consultant			0	10a-3	42
Speech Therapy Consultant	F		0	10a-3	43
Activity Consultant	E		2,167	11-3	44
Social Service Consultant	E		0	12-3	45
Other(specify)	S				46
PSYCHO-SOCIAL CONSULTANT			2,065	10-3	47
					48
TOTAL (lines 35 - 48)		$	25,096		49

ONTRACT NURSES

	1 Number of Hrs. Paid & Accrued		2 Total Contract Wages	3 Schedule V Line & Column Reference	
Registered Nurses	1,136	$	3,523	10-3	50
Licensed Practical Nurses	1,564		45,802	10-3	51
Nurse Aides	1,450		26,388	10-3	52
TOTAL (lines 50 - 52)	4,150	$	75,713		53